STATE OF ARIZONA

HEALTH INSURANCE TRUST FUND

PERSONAL PAYMENTS

(Please make checks payable to ADOA-HITF)

NAME: (LAST)	(FIRST)		
S. S. #: - -	AGENCY NAME:		AGENCY CD:
BENEFITS PERIOD COVERED		INDEX #	PCA #
From:	Through:		

PREMIUM PAYMENT DATA

CIRCLE LEAVE TYPE: **FMLA** **NON-FMLA** **2-wk EXTENSION**

PLAN CODE	INSURANCE COVERAGE	EMPLOYEE PREMIUM AMOUNT	EMPLOYER PREMIUM AMOUNT
	MEDICAL		
	DENTAL		
	VISION		
	BASIC LIFE		
	SUPPLEMENTAL LIFE		
	DEPENDENT LIFE		
	SHORT TERM DISABILITY		
	LONG TERM DISABILITY (CIGNA)		
	MEDICAL SPENDING FSA (AMRA)		
	DEPENDENT CARE FSA (DCRA)		
	TOTAL PREMIUMS		

WE CERTIFY THAT FOR THE PERIOD SPECIFIED, THIS EMPLOYEE IS ON APPROVED LWOP.

Signature _____ Date _____

Check No. _____ Preparer's Telephone No. _____